

Reducing Preventable Deaths Among People Who Use Drugs

Winston Churchill Memorial Trust
Travel Fellowship 2015

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Many thanks to Kevin's Mum for sharing her story...

KEVIN (1972 – 2001)

My Son, Kevin (an only child) died from a heroin overdose on the 21st October 2001 outside a dealer's house. He was 28yrs old.

His battle with addiction lasted 14 years. It started with glue sniffing, magic mushrooms and other mind-altering substances. He went from a lovely, happy boy to a very dark and morose individual, which I thought was caused by going through teenage angst. This turned out not to be the case.

I became aware of how bad things were when I was contacted by the police after Kevin had been detained on a charge of shoplifting and my son's drug fuelled journey began, his offending escalated and he was imprisoned on several occasions.

I felt completely out of my depth and had no access to any form of services (at that time there wasn't anything to tap into) my helplessness and frustration hastened the feelings of resentment I felt towards him which in turn made me feel guilty and ashamed. I so wanted to make it all go away.

Over the next 7 years I watched a happy little much loved son turn into a wreck – unkempt, unable to show any kind of human emotion except the need for heroin - nothing else mattered. The offending got worse and my life was completely overtaken by my need to protect and help him. This was a long period of worry and family life became strained. My husband worked abroad and was away a lot - he just couldn't understand why this was happening - he just couldn't cope with the situation and our relationship became tense as he felt that we should just give up. I knew he didn't mean it but it was his way of coping. I was determined I would fight to the last to get Kevin back on track however long it would take.

At the beginning of 1994 Kevin was convicted of a crime and imprisoned for 6 years. If I am honest it was a relief - I knew where he was and hopefully he might receive help for his addiction.

I went to visit once a week and he and I had so many different emotions going on – anger, hopelessness. It scared me that there were no addiction services at that time in the prison and I believe he was accessing substances while there.

As his sentence neared completion there had been an improvement as some sort of drug access facility opened and Kevin had become engaged with that. When he was released he went to live with his girlfriend who had been a user also but was on a methadone script. It was with trepidation that we encouraged them but we helped in any way we could, it was so comforting to see them both in a normal setting and Kevin seemed happy. I felt I had got my beautiful boy back on track at last.

He was 28 years old. He was a man with a teenagers mind as he had lost that part of his life to his drug addiction. He had been abstinent of all drugs for 6 months and according to his GP was doing well apart from his Hepatitis but seemed happy enough...

The night before his death he came for a visit and seemed on edge. We had a long conversation and it turned out that his partner had started using again. He was angry as he didn't want to be around the paraphernalia that went along with it and I wanted him to stay the night so he could think about what to do, as he was still vulnerable. But he went home. He left me with a hug and a kiss told me he loved me and thanked his dad and I for all our help - that meant the world to me.

The next time I saw him he was lying on the pavement outside his partners dealers house.

I had been called and told where he was I raced to get to him and proceeded to do CPR until the ambulance arrived but he was dead.

That was my last memory of him - my beautiful boy, gone in an instant.

I hide my grief within myself and life has to go on but I shall never forget my dear Son.

I am so glad we now have take-home naloxone. At least it gives one a chance to save a loved one's life.

I also had the pleasure of watching a video showing the benefits of the Medically Supervised Injecting Centre situated in Australia. It was heartening to hear how warmly the staff welcomed people - to me this can only be beneficial in keeping the drug taking community safe, building up confidence, giving back dignity and self worth to a marginalised group of people.

I am fully committed to embracing this kind of facility in Scotland in the near future.

Kevin's Mum

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ABBREVIATIONS

| | |
|------|---------------------------------------|
| DCR | Drug Consumption Room |
| DRD | Drug-Related Death |
| MSIC | Medically Supervised Injecting Centre |
| NHS | National Health Service |
| NSW | New South Wales |
| ORT | Opiate Replacement Therapy |
| PWUD | People Who Use Drugs |
| SIF | Supervised Injecting Facility |
| THN | Take-Home Naloxone |
| UK | United Kingdom |
| WCMT | Winston Churchill Memorial Trust |
| WHO | World Health Organisation |

ABOUT ME

I began working with people who use drugs when I first qualified as a mental health nurse in an acute mental health hospital. Following this I went on to work in a Community Addictions Team and I now coordinate a National Overdose Prevention Programme at Scottish Drugs Forum.

I have known and worked with many people who have tragically lost their lives to accidental and preventable drug overdose deaths and strongly believe that more can be done to reduce and ultimately prevent future losses.



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EXECUTIVE SUMMARY

Drug-related deaths (DRDs) are a cause for major concern, Nationally and Internationally. The number of lives lost every year from accidental overdoses is incomprehensible and in the UK, whilst we have many strategies, services, organisations and individuals trying to address this issue, the rising number of deaths calls for further action to be taken.

The purpose of my 6 week trip to Melbourne, Malaysia, Sydney and Perth was to investigate how services differ in Australia for people who use drugs and to see what learning could be brought back regarding the prevention of DRDs to the UK to further inform our practice and future direction.

I knew from the start that one of the major recommendations would come from my time spent in Sydney's Medically Supervised Injecting Centre (MSIC) and that spending time there would help strengthen the argument having had that hands on experience, but I also wanted to research other factors. I wanted to see what other services were available to people - the availability of opiate replacement therapy, treatment engagement and retention and low threshold services.

Scotland has a world renowned National Naloxone Programme, which was introduced by the Scottish Government in 2010 in response to the rising number of drug-related deaths. Naloxone is a medication that reverses the effects of an opioid overdose, which is administered by injection. By giving people who use drugs access to take-home naloxone (THN) kits, they can administer the medication quickly in an emergency to their peers, saving vital time before the ambulance arrives. Australia has access to THN in some areas but many were keen to learn more from the Scottish experience and therefore I was also able to share the knowledge on this in return. In addition to many meetings on the subject I was also very privileged to present at the Centre for Research Excellence into Injecting Drug Use (CREIDU) Colloquium in Melbourne, the International Harm Reduction Conference in Malaysia and the Australasian Professional Society on Alcohol and other Drugs (APSAD) conference in Perth, where I also facilitated a 3 hour workshop.

Given that my current work relates to Scotland, and that I am able to directly bring my findings to key stakeholders due to the nature of my work, this report will focus on the situation in Scotland but the findings and recommendations are entirely transferable to the rest of the UK. I will also be drawing on not only the evidence from Australia, but also some of the work being done by Scottish Drugs Forum on death prevention strategies.

There are 3 main recommendations that are explored in more detail at the end of this report:

- **SUPERVISED INJECTING FACILITIES:**

Wherever there are significant numbers of people injecting in public, there is a clear need for supervised injecting facilities.

- **TAKE-HOME NALOXONE:**

Take-Home Naloxone should be available free of charge, and promoted widely, to those most likely to witness an overdose.

- **ACTIVE ENGAGEMENT AND RETENTION IN TREATMENT SERVICES:**

Low threshold services should be widely available across the country.

BACKGROUND TO PROJECT

There were 3,346 drug poisoning deaths registered in England and Wales in 2014, the highest since comparable records began in 1993. The mortality rate from drug misuse was the highest ever recorded at 39.9 deaths per million population. (Office for National Statistics)

In Scotland, 613 people lost their lives from drug-related deaths in 2014 and like the rest of the UK, this was the highest number recorded since records began. (National Records of Scotland). These deaths in Scotland are overdose deaths only, so they do not include deaths from blood-borne viruses, bacterial infections or anything else related to drug use. The overwhelming majority of these deaths were **accidental** and therefore **preventable**.

Scotland has an estimated 61,500 people who use drugs problematically and rates of DRDs are among the highest in Europe. Most people who die are not in treatment at the time of their death but have been in contact with services within the six months prior to their death. A matter of huge concern, which requires further exploration, is the high number of unplanned discharges from drug treatment services. Being in treatment is a protective factor against fatal overdose.

Part of my trip was going to be spent in the Sydney MSIC and would result in being a large focus of my project. So prior to my visit there I used this as an opportunity to further develop the discussions on this topic in Scotland.

Firstly, I circulated an Opinion Survey on Drug Consumption Rooms for Scotland, which provided me with valuable insights to guide my discussions with key stakeholders in Scotland

I met with people who use drugs, Scottish Government, Police Scotland, Crown Office, Health Protection, Public Health and many others to go through the survey results, inform people of my plans and glean some insight into the current think around such a service being developed in Scotland.

The meetings were all very positive and whilst people may not have been in a position to publicly state their support for DCRs, there was no resistance noted from any of the people I met with.

Having been a member of the Scottish Government's National Forum on Drug-Related Deaths since 2012, I have been involved in many discussions and reviews of the international evidence, which have shaped the annual recommendations from the Forum. A consistent recommendation has been for the introduction of Drug Consumption Rooms.

RECOMMENDATION FOUR: HEROIN ASSISTED TREATMENT AND DRUG CONSUMPTION ROOMS

In previous reports the Forum has made recommendations promoting the development of local services to include heroin prescribing and safe injecting facilities where necessary. The Forum notes that injecting drug use, particularly opioids, remains a significant risk factor for drug deaths as does being out of structured treatment or poor response to ORT. In addition, the Forum notes recent national outbreaks of anthrax and Botulism in Scottish injecting drug users. The Forum has discussed the format and structure of such a facility and considers that along with the well understood functions of delivering heroin assisted treatment the project could act as a coordinating centre for services for injectors, a harm reduction agency to intervene in cases under severe stress and to provide reactive data in a rapidly changing drug taking environment.

Therefore, the Forum repeats this recommendation but further recommends that the scoping, establishment and evaluation of pilot services in one or two ADPs where the need is most, is seen as a national priority and supported by government and national agencies.

(NFDRD Annual Report 2014, published May 2015)

In summary, this was the order of events for my Fellowship:

- Opinion Survey on DCRs for Scotland circulated
- Meetings held with key stakeholders in Scotland
- Travel to Melbourne
- Travel to Malaysia
- Travel to Sydney
- Travel to Perth
- Meetings held on return with key stakeholders in Scotland

THE SURVEY

Many thanks to everyone who contributed their opinions for this survey, the results of which are presented below.

It is recognised that there are several limitations to this survey so it is not suggested that it is a full representation of the views of key stakeholders working in the drug treatment and care services in Scotland. The survey was only live for two weeks online via Survey Monkey and was not actively directed at or necessarily available to people who use drugs, which is obviously something that will be prioritised and researched in due course. The purpose at this stage was to gain a quick snapshot of opinions and questions to help inform and lead my project by adding to the discussion with stakeholders in Scotland and staff from Sydney's MSIC.

There were **428 responses**, but it should be noted that not all 428 people answered fully.

The majority of respondents were working in the voluntary sector (39%) followed by health services (20%) with the remainder being government, police, prison service, social care and peers/volunteers. Those who marked 'other' included people who use drugs and a broad range of other backgrounds and disciplines.

23% of respondents were from Greater Glasgow and Clyde, followed by Lothian (16%). The only health board areas not represented were Orkney and Western Isles. People from out with Scotland also responded and made up around 8%.

74% of people were supportive of MSICs/DCRs, with 19% being unsure and 7% not in support.

The following themes presented from those in support and the text in brackets highlights some of the comments made:

- Safety - for users (sterile and hygienic environment) and the community
- Reducing drug-related deaths (staff on hand to respond to overdoses)
- Reduce sharing of injecting equipment (less blood borne virus (BBV) transmission)
- Cost saving (less ambulance call-outs and BBV treatment)
- Engagement in services
- Education and information
- Reduce medical problems (BBVs, wounds, early identification of bacterial infections)
- Reduce discarded injecting equipment (less needle litter)
- Reduce public injecting
- Promote recovery
- Reduce stigma
- Evidence

One respondent said the following:

"Having used the one in Sydney when I was still using I saw first hand the effectiveness of the service. I was treated with dignity and respect and was able to use in a safe, monitored environment. Without it I would have had to resort to riskier behaviour. Talking with other addicts in the Kings Cross area they confirmed drug deaths in the area had fallen. Here in Scotland a facility like this would save lives and give moments for brief interventions which may lead someone to seek further support for their addiction issues."

There were 84 responses from those who felt unsure or not in support of a MSIC/DCR which have been grouped or noted below (in no particular order)

- Lack of understanding about such a service (main response in this section)
- Lack of resources
- Encourages drug use
- Negative policing
- Impact on children
- Doesn't aid recovery
- Drug users congregating around the service
- Needs large scale population to be viable
- Effect on nurses/staff

66% of people felt Greater Glasgow and Clyde was most in need of a MSIC/DCR, followed by Lothian (8%). 77% of people would be supportive of an MSIC/DCR in their own health board area.

There were 71 comments on why people did not support this in their own area (or were unsure), which centred around –

- Lack of understanding
- Rural nature
- Cost

When asked what type of services people would like to see offered, all of the following received more than 80% from the choices provided –

- A safer injecting environment
- A safer environment where drugs could be injected and inhaled
- Wound care
- BBV testing/vaccinations
- Access to drug treatment
- Take-home naloxone
- Mental health services
- Links to mutual aid

BBV treatment and social interventions received 79% and 78% respectively. There were 55 'other' responses which included many other services, an example of some are listed below –

- Non-judgemental staff
- Heroin-assisted treatment
- Dental services
- Sexual health testing/treatment

One respondent stated the following:

"The DCR needs to be able to process people fairly quickly to deal with demand. The priority has to be immediate safer injecting. It shouldn't replicate services available elsewhere but provide a unique service."

The last part of the survey asked people 'what questions would you like addressed from Sydney's experience of their MSIC? (opened in 2001)' - and there were 188 responses. These were grouped/themed to a more manageable number and are included in the findings section.

In Summary:

- The majority is supportive of DCRs for Scotland.
- The majority feels that Glasgow is most in need of a DCR.
- The survey highlights the need for wider dissemination of the benefits of Supervised Injecting Facilities.

The full survey results can be accessed [here](#).

FINDINGS (from Australia)

AUSTRALIAN NATIONAL DRUG STRATEGY

Harm Minimisation is at the core of the Australian National Drug Strategy. The latest version of the strategy is still in draft form at time of writing. (Draft National Drug Strategy 2016-2025 Consultation, Australian Government)

1.1 Aim

The aim of the National Drug Strategy 2016-2025 is:

To contribute to ensuring safe, healthy and resilient Australian communities through minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

1.2 Harm Minimisation Approach

Australia's long standing harm minimisation approach has consistently addressed alcohol, tobacco and other drug issues to prevent or reduce the harmful effects of alcohol and other drug use. This approach considers the health, social and economic consequences of drug use on both the individual and the community as a whole and is based on the following considerations:

- Use of drugs, whether licit or illicit, is a part of society,
- Drug use occurs across a continuum, from occasional use to dependent use,
- A range of harms are associated with different types and patterns of drug use,
- Response to these harms can use a range of methodologies.

This approach reduces total harm due to alcohol, tobacco and other drug use through coordinated, multi-agency responses that address the three pillars of harm minimisation. These pillars are demand reduction, supply reduction and harm reduction. Strategies to minimise the harm from alcohol, tobacco and other drug use should be coordinated and balanced across the three pillars.

1.2.1 Three pillars of Harm Minimisation

Demand Reduction

Demand reduction includes strategies and actions that prevent the uptake of drug use, delay the first use of drugs, and reduce the harmful use of alcohol, tobacco and other drugs in the community. It also includes supporting people to recover from dependence and enhance their integration with the community.

Supply Reduction

Supply reduction includes strategies and actions that prevent, stop, disrupt or otherwise reduce the production and supply of illicit drugs; and control, manage or regulate the supply of alcohol, tobacco and other licit drugs.

Harm Reduction

Harm reduction strategies aim to reduce the negative outcomes from alcohol, tobacco and other drug use when it is occurring by encouraging safer behaviours, creating supportive environments and reducing preventable risk factors.

NALOXONE PROVISION

Australian regulations regarding naloxone provision and administration differ slightly from the UK, which can be problematic at times.

There is a real will among the sector to provide take-home naloxone (THN) and some excellent examples of this with individual workers doing a supreme job in getting naloxone to those who need it, but good will is not enough and some of the legalities and systems make it much more restrictive than is necessary.

People providing naloxone are required to have each individual prescription signed by a doctor so there is no equivalent Patient Group Direction supply taking place like we utilise in Scotland. This therefore relies on creativity among workers and is often successful due to good relationships rather than by design. It means that there is not always the opportunity to provide people with THN immediately and opportunistically and often requires workers tracking people down or seeing people at a later date to provide it. Barwon Health in Victoria has a free phone number for people to contact the naloxone lead for THN, which is an excellent idea to try to engage more people.

Drug workers are not supported organisationally to administer naloxone in an emergency while they are on duty. If they were off duty they would be covered by a Good Samaritan Law. So for example, if an outreach worker who delivers

naloxone training comes across someone who has overdosed they are required to call a 'code blue' to their organisation and a doctor will come running to wherever they are (assuming it's nearby) to administer it. Or, in many cases, a peer will administer the naloxone, whilst the worker (who probably trained said peer) watches on. This is very frustrating for all concerned.

THN is provided as 0.4mg mini-jets so five syringes are supplied at a time in case multiple doses are required. There are pros and cons to this. One of the problems is the sheer bulk of equipment to be carried around and the fact that needles need to be provided separately. The provision of facemasks for rescue breathing is standard practice.

There is no naloxone-on-release for people leaving prison but the discussions are happening. This is a crucial time for people to receive naloxone due to the well-documented and evidenced high risk of overdose following prison liberation.

A very exciting development for naloxone in Australia whilst I was there was the expected rescheduling to Schedule 3, which is the equivalent of a Pharmacy Medicine in the UK and essentially means that it will be available from a pharmacist over the counter.

This has since taken place and can now be purchased throughout the country but there will still be work to be done to ensure that those who cannot afford to buy naloxone have access more readily.

ENGAGEMENT AND RETENTION IN TREATMENT (PHARMACOTHERAPY)

An unexpected finding in Australia was that people who are prescribed opiate replacement therapy (ORT) are required to pay a pharmacy dispensing and administration fee of around \$5 for each dose. This can be a real problem for some, particularly those with very little income. There are instances where people starting ORT have previous debts with the pharmacy and are required to pay this off and a start up fee prior to receiving their prescription, resulting in delays or inability to proceed. There are programmes in some services to assist and support with initial payments but these are not permanent solutions and not available to everyone.

Most needle and syringe programmes (NSPs) also charge for equipment, others will fund this provision through their individual services. Not all NSPs will have suitably trained staff providing the equipment so the potential for using that brief interaction as an opportunity for advice or interventions is limited.

However, some areas also have dispensing machines where equipment can be purchased and may be preferred or required (if out of service hours) by some. The provision of sharps disposal units across the country is to be admired. Every public toilet had them, including the airport toilets, and they were also situated on the streets, which were visible to those who knew what they were but also discreet enough that they may not be recognised as such.

Most of the prescribing of ORT is by doctors/GPs, which differs from Scotland since a majority of prescribing is via doctors (mostly psychiatrists) attached to Community Addiction Teams. The Australian method seems to provide better retention on ORT since people are very unlikely to be discharged for non-compliance with the service's expectations (ie. no illicit drug use or missing appointments).

Immediate access to treatment was available by some services, who were able to start people on ORT on the day that they present and others who were generally within the week. There was recognition that this was not the case in all areas due to some of the rural locations and problems logistically.

LANGUAGE

Rather than 'drug and alcohol' services, people in Australia refer to 'alcohol and other drug' (AOD) services which is much more appropriate as it gives more emphasis to the fact that alcohol is indeed a drug.

During my time meeting with numerous people, not once did I hear anyone refer to substance 'misuse', drug 'abuse', 'addicts' or any other such terms, which add a level of judgement, stigma and discrimination. Language is incredibly important in the AOD sector and people first language should be used at all times. Even the simplest of terms are often overlooked, eg. 'dirty' and 'clean' when talking about drug testing results and injecting equipment.

SUPERVISED INJECTING

“I was fortunate enough to get a visa for one year as a joiner in Australia.

When I was there I stayed in a hostel in Randwick where I met a guy who worked in the City. He was also a heroin user. After work we would stop in Kings Cross, where he would meet his dealer to buy heroin. He told me that Kings Cross was the place to buy the best, strongest heroin in Sydney.

He also told me about the consumption room, where he was known to the people who worked in there. I went in with him and was made to feel very welcome and my friend thought very highly of the service. The workers knew him by his first name and I noticed how friendly they were. There was a good atmosphere, it was really clean and reminded me of a real sterile smell. Sitting myself, I took in the people coming and going – there was no stigma and I didn’t feel judged in any way. The workers were down to earth, open-minded and you could talk to them about anything.

For me, using the injecting centre was the safest option. I was met with a happy face, was able to get a clean set of works and someone was watching over me incase I went over.

I think Scotland would benefit greatly from providing this service because hundreds of lives would be saved.
I also believe a lot of my friends would still be here if they’d had somewhere like this to go.”

Andrew, Scotland



In the UK right now, thousands of people are injecting drugs in public places that are very often unsanitary, unhygienic and **unsafe**.

Before heading to Australia I took the opportunity to explore some of the areas in which people are using drugs in Glasgow City Centre. Research conducted by Blake Stevenson (2009) estimated that approximately 2,290 people injected drugs in public per week in Glasgow.

Left: one of many public injecting sites in Glasgow City Centre



Above: used and discarded injecting equipment



Above: evidence of needles, syringes, spoons and water for injection

As you can see, there are multiple discarded needles and syringes and huge amounts of injecting paraphernalia. This site is fairly new following the displacement from the 'clean up' of another site and is estimated to have up to 200 people frequenting it.

It is also acknowledged that in times where people may be in immediate need of injecting equipment, this type of site may be accessed to re-use needles which is incredibly risky practice in terms of the potential for contracting blood-borne viruses and infections. There is also the potential for needle-stick injuries from the unsuspecting public.

The most time I spent in one service during my trip was in Sydney, within the Medically Supervised Injecting Centre – the first and only facility of it's kind in Australia.

What Is A Supervised Injecting Facility?

SIFs, MSICs, and DCRs are all terms used to described legally sanctioned sites where people who use drugs can use their pre-obtained drugs under supervision from suitably trained staff. The term DCR is usually used to describe facilities that also provide space for the inhalation and/or sniffing of substances as well as injection.

I have come to discover that the terms SIF and MSIC appear to be more acceptable than DCRs when presenting to some groups.

There are various models of SIFs worldwide, with the total number in 2014 being 88 centres in Denmark, Germany, Netherlands, Norway, Spain, Switzerland, Canada and Australia (Global State of Harm Reduction, Harm Reduction International, 2014). There are only two centres outside Europe. The first DCR opened in Berne, Switzerland in 1986, so the evidence base for such facilities now goes back 30 years with no less than 135 published research papers on the subject (listed in the references section).

What Are The Main Objectives?

- To reach as much of the target population as possible
- To provide a safe environment that enables lower-risk, more hygienic drug consumption
- To reduce mortality and morbidity in the target population
- To stabilise and promote the health of people who use drugs
- To reduce public drug use and associated nuisance (discarded injecting equipment etc.)
- To avoid increases of crime in and around the facilities

*Taken from research by Hedrich, D (2004)¹

The evidence of effectiveness to meet these objectives is overwhelming.

Essentially, SIFs should be seen as an extension to needle and syringe programmes - if we are providing people with sterile equipment to inject drugs, we should also be providing a sterile environment in which to do so.

Sydney's Medically Supervised Injecting Centre

The MSIC opened in 2001 under trial status. In 2010 the NSW Parliament voted to overturn the trial status, almost a decade after opening.

Objectives:

- Optimise health by saving lives and reducing injury from drug use
- Effectively intervene in the event of drug overdose
- Provide access to health and social welfare services for a marginalised and difficult to reach population
- Uphold and promote the dignity of all people who use the service and promote awareness and understanding in the community
- Contribute to the amenity of the local community, for example by reducing injecting drug use and syringe disposal in public locations
- Contribute to the body of public health knowledge around injecting drug use

Research:

- Number of ambulance call-outs to Kings Cross reduced by 80% after MSIC opened
- 70% of local businesses and 78% of local residents support MSIC
- MSIC had no negative impact on crime in the Kings Cross area
- Independently evaluated as cost-effective
- The number of publicly discarded needles and syringes approximately halved in Kings Cross after MSIC opened
- Provided over 62,000 medical and support services onsite

Facts*:

- MSIC has supervised more than 930,000 injections and managed 5,925 overdoses without a single death
- There have been ZERO fatalities onsite since MSIC opened
- A total of 15,054 people have registered to use the service
- About 70% of the people registered had never accessed any local health service before
- More than 11,678 referrals have been made, connecting people to health and social welfare services
- Each year more than 2,000 individualised nursing and support services are provided onsite

*as of May 2015

What Does The MSIC Look Like?

Location is crucial. SIFs should be situated where the sale, purchase and use of drugs is occurring. The MSIC is in Kings Cross, which was a concentrated spot for drug overdoses indicated by the number of ambulance call-outs to the area.



Left: the discreet entrance to the MSIC in Kings Cross, Sydney

Stage One: Waiting Room and Assessment Area

When people enter the facility the first part of the process is to register (if it is their first time) which takes around 10-20 minutes. For subsequent visits people give their password to the reception staff who will also ask them a couple of questions about what they intend to inject, when they last used and what drugs they have used in the past 24 hours. This provides a quick overdose risk assessment and an opportunity to provide harm reduction advice.

Stage 2: Injecting Room

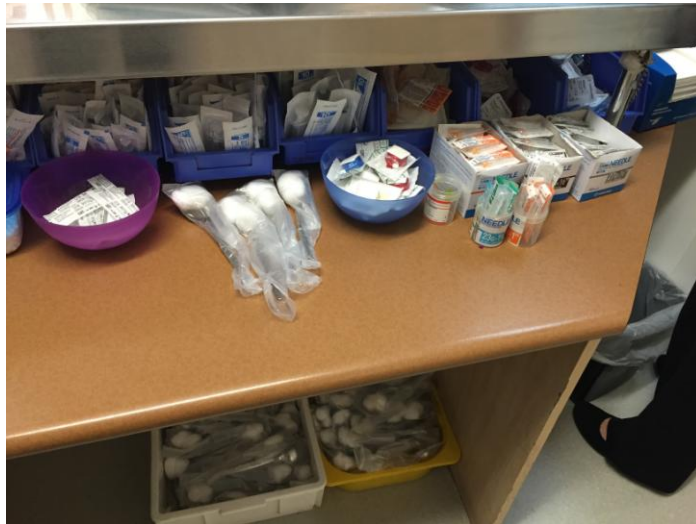


This is where clients prepare and inject drugs. It is the only place in Australia where it is legal to possess and inject a small amount of drugs for personal use.

Left: entering Stage 2

Clients approach staff at the counter to get the equipment they need and the following things are provided in any quantity requested:

- 1ml fits
- Syringes (3ml, 5ml and 10ml)
- A range of different sized needles (plus small quantities of butterfly ones if needed)
- Normal filters and wheel filters
- Swabs
- Water
- Tourniquets
- Spoons (plastic or metal)
- Cotton wool
- Band Aids
- Citric (normally used with Fentanyl as the heroin in Australia does not require it)



Above: injecting equipment behind the counter

Once people collect their equipment they head to one of the 16 stations in the 8 booths (booths can be shared but only if the two people have entered the centre together with that intention).



Remember that people are still required to bring their own drugs – the centre does not provide them!

All types of different pre-obtained drugs are injecting here including heroin, cocaine, oxycodone, morphine, methamphetamines and benzodiazepines.



Above: 8 booths are available. Right: safe disposal units are in all booths

Stage 3: Aftercare Area

This area is where people can relax following Stage 2 and can interact with staff informally. Tea and coffee is available and this is where staff can offer counseling services, which often leads to referrals to other services.



Health promotion topics are mostly promoted in this area and staff develop different campaigns and materials on a monthly basis.

Left: Stage 3 Aftercare Area

“Each time people come to MSIC, they are treated with dignity and respect. This should be essential for any service, but it’s even more important for our clients who are already stigmatised, often homeless, mentally ill, and have been treated poorly most of their lives. It’s the thing clients most frequently say to us; thank you for treating me like a human being.”

Dr Marianne Jauncey, Medical Director Sydney MSIC (quote taken from Cross Currents, The story behind Australia’s first and only Medically Supervised Injecting Centre)

Survey Questions and Answers

The afore mentioned survey results produced many questions to bring back from Sydney, which are collated below. See references section for all Sydney MSIC evaluation papers.

| Questions for Sydney's Medically Supervised Injecting Centre from the Opinion Survey on Drug Consumption Rooms for Scotland | | |
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| No. | QUESTION | ANSWER |
| 1 | Has there been a reduction in drug-related deaths in the area? How many overdoses have occurred in the MSIC and have any of them been fatal? | Without a doubt. Statistically however, this is more difficult to directly attribute to the MSIC due to the heroin drought that the area experienced following the introduction of the service, which may also have contributed to a reduction in DRDs. What can be shown is that there has been an 80% reduction in ambulance call outs for overdoses in the immediate surroundings of the centre, which is far greater than any reduction elsewhere in the state. The MSIC has managed 5925 overdoses without a single death . There have been ZERO overdose fatalities in any SIF anywhere in the world . Elsewhere, researchers found a decrease of 35% in overdose mortality in the area around 'Insite' (the supervised injecting facility in Vancouver) following its opening. |
| 2 | Has there been a reduction in illicit drug use or any changes in injecting patterns? | SIFs do not directly impact or change community drug use patterns but they do make contact with people who are very marginalised and often entrenched in problematic drug use, some of whom have never been in contact with any other services. People who have never used drugs do not start because of the MSIC being available. The MSIC allows for real time drug use patterns, which is extremely beneficial. |
| 3 | What has the impact been on the local community? | Importantly, the local community has always been supportive. One of the |

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| | <p>Are there any complaints from the public and has there been a shift in social acceptance since the MSIC opened?</p> | <p>recommendations from the Drugs Summit in 1999 was that a centre could only be established in an area where the locals were broadly in agreement. There has never been any widespread opposition despite what may have been portrayed in the media. There has been a huge reduction in needle litter and public injecting which has been a welcome change. Prior to the MSIC people were often being found in alleyways and in the street having overdosed - this is now very rare.</p> <p>For businesses and communities with a public injecting problem, a SIF is the answer to your problems. Community views are sought through consultations and the household survey.</p> <p>Local residents and businesses have reported significant improvements in the area.</p> <p>Complaints are very rare and are always responded to promptly by the service.</p> <p>70% of local businesses and 78% of local residents support MSIC.</p> |
| 4 | <p>Have levels of crime in the area reduced?</p> | <p>Acquisitive crime reduction across state due to heroin drought. People still have to source their drugs illicitly however the important point to note is that there has been no increase in crime following the introduction of the MSIC. The drug use was already there.</p> <p>The general feeling is that Kings Cross is a much safer place these days and the police I spoke with related this mostly to the MSIC.</p> |
| 5 | <p>Have levels of blood-borne viruses (BBVs) declined?</p> | <p>General injecting safety and techniques are improved and because people are not sharing equipment, transmission rates of BBVs are reduced.</p> <p>Most people who attend the MSIC already have a long history of drug use and many have previously contracted Hep C.</p> |

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| 6 | Has there been an increase in the numbers of people accessing treatment? | <p>People attend the MSIC much earlier than they would access other services. The more times people attend the MSIC, the more likely they are to accept treatment referrals. These referrals may never have occurred without the MSIC.</p> <p>More than 11,678 referrals have been made, connecting people to health and social welfare services.</p> |
| 7 | <p>How long did the process take to get the MSIC established?</p> <p>What was the rationale for its introduction and location?</p> | <p>In 1997 the Royal Commission into NSW Police Service recommended a supervised injecting centre in Kings Cross, which was again recommended at the Drug Summit in 1999. The centre opened in 2001.</p> <p>Overdose deaths were the main rationale for the service and it was situated where the majority of ambulance call outs for overdose would attend.</p> |
| 8 | <p>What are the criteria for access to the MSIC?</p> <p>Can people be excluded?</p> | <p>Anyone can attend the service to inject any drug. However, there are some exclusion criteria;</p> <ul style="list-style-type: none"> - Under 18 years old - Never injected before - Heavily intoxicated - Pregnant <p>The view of the service is that it's poor medical practice to exclude underage or pregnant women. The MSIC are seeking to address this and would produce comprehensive guidelines to provide the service to try to engage people with the correct help rather than turning them away (current legislation prevents the MSIC allowing entry).</p> <p>Currently neck injecting is not permitted in the service.</p> <p>Occasionally people will receive a 'time-out' rather than a 'ban' from the service but that is very rare and generally due to threats/violence.</p> |
| 9 | What evaluation system was used? | Multiple evaluations have been undertaken – the list of key papers is provided |

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| 10 | How did you get the message over to those not in favour? How did MSIC manage the media, politicians and public relations and do they have any advice for Scotland? | Being open and transparent, offering tours, answering questions honestly. A communications manager was also on hand to assist and advise. It is important for health and police to work together. |
| 11 | Are there any disadvantages? Does it give the 'wrong message' about drug use? | The service does not encourage drug use and no disadvantages have been noted. It is essentially an extension of a needle and syringe programme. Medical Director: the message the MSIC gives is that "you as an individual are important" |
| 12 | What are the views of people using the MSIC? Any negative opinions? | Comments books have been provided since the service opened. People speak very highly of the service as a place where they are treated with dignity and respect , and many describe it as a service that has saved their lives . A common request is that the service opening hours are extended. |
| 13 | Is the MSIC cost-effective? | 3 economic evaluations have been undertaken of the MSIC and are complex (the papers are referenced below) It has been independently evaluated as cost-effective . Most of the savings are made through prevention – prevention of BBVs, injecting related injury, disease and infections, serious overdose including death. Sometimes this is hard to measure. One of the evaluations found that the centre only had to save 0.8 of one life every year to be cost neutral. A very recent paper from Canada concluded that it is likely to be cost-effective to establish at least 3 SIFs in Toronto and 2 in Ottawa. |
| 14 | How many people use MSIC? Is the uptake what was expected? Does MSIC have many returning clients? Age/gender/in employment? | The demographic profile of SIFs worldwide is very similar. 75% male, older (35+), long history of drug use and history of overdose, history of public injecting, poorly connected, history of prison, mental illness and often homeless. Most clients use the service regularly, sometimes several times a day. A total of 15,054 people have registered and |

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| | | <p>to date, the MSIC has supervised more than 930,000 injections.</p> <p>About 70% of people registered had never accessed any local health service before.</p> <p>The majority are unemployed but a proportion of people are working, this is why opening hours are important.</p> |
| 15 | <p>Has MSIC been heavily policed? What are the relationships like with law enforcement and what are their views? How did MSIC overcome the legal aspects? Has MSIC become a target for dealers and do people congregate?</p> | <p>There was an amendment to the Drug Misuse and Trafficking Act that allows the centre to operate.</p> <p>It is very important to have a good working relationship with the police, which the MSIC does.</p> <p>The MSIC is not a 'no go' zone for police and they continue to police the area as required. They do not specifically target people heading to the MSIC.</p> <p>The MSIC is situated in an area where dealing was already taking place so the service has not changed that. People do not travel in from other areas to use the centre and there is no congregating outside. Sometimes there are one or two people waiting nearby in the morning for the centre to open but people want to avoid the police so are therefore unlikely to hang around, particularly if they are carrying drugs. The police I spoke with were extremely supportive of the centre.</p> |
| 16 | <p>What are the MSIC main aims/outcomes?</p> | <p>One of the main aims is to stop people dying of overdose but it's the morbidity as well as the mortality which is just as important. Hypoxia from overdose can cause significant harms if not treated promptly.</p> <p>The MSIC aims to increase contact with marginalised people who inject drugs, reduce transmission of HCV and HIV and reduce public injecting and discarded equipment.</p> <p>The provision of real time drug trends is also extremely useful.</p> <p>Being there when people inject allows staff to identify times when heroin appears to be higher purity and to alert clients and other services of this immediately.</p> |

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| 17 | What is the advice for Scotland in taking forward this agenda? | Find your champions – politicians, business people, community members, police, faith-based organisations and find the right person to talk to these people. |
| 18 | How is MSIC funded? | The confiscated proceeds of crime funds the MSIC. Most of the annual running costs (around \$3.3million) is on staffing. The centre has a mandatory minimum staffing level. |
| 19 | What are the main drugs injected? | Mostly opiates such as oxycontin and heroin. Other drugs include fentanyl, methamphetamine, cocaine, methadone and benzodiazepines. Any drug can be injected in the centre. |
| 20 | What services are offered at MSIC on site and what services are clients signposted to most regularly? Do people ask for additional services that are not on offer? | Each year more than 2000 individualised nursing and support services are provided onsite. Services provided on site include – mental health input, housing, take-home naloxone, injecting equipment provision (for take away at stage 3), wound care, nicotine replacement therapy, OWL (one who listens) sessions and liver clinics. They have also been doing a yearly art project. Referrals are generally made to the Kirketon Road Centre for opiate replacement therapy, sexual health screening and other services not provided by the MSIC. People would like the service to provide accommodation, for crisis or detox. |
| 21 | Is there any continuing research ongoing? | Because of the nature of the service, research is always on the agenda. There is a part-time research post based in the centre. |
| 22 | Are there many high risk situations or incidents? How does MSIC ensure a safe working environment for staff? | Most high risk situations are avoided by treating people well and the de-escalation skills of staff. There are very rarely any incidents of violence and aggression but there is always a security officer on shift and the police can be called if necessary. Most of the difficult situations involve people who have taken benzodiazepines and can be difficult to |

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| | | <p>manage.</p> <p>Staff training is essential.</p> <p>Overdoses are frequent and the most common issue to deal with.</p> |
| 23 | Has there been any effect on homelessness in the area? | There are reportedly not enough services for homeless people in Kings Cross. The centre has a housing support worker to assist clients of MSIC but there appears to be a real shortage of emergency accommodation. |
| 24 | What is the child protection policy? | The service operates in the same way as any other service in this matter. They are mandatory reporters so if they feel a child is at risk they will act on their duty of care and report it to the relevant bodies. |
| 25 | Do people inject more safely when using MSIC? | <p>Yes. Often people develop poor injecting techniques over time and have never been given advice on harm minimisation. People don't always have access to running water to wash their hands or always have sterile equipment to use.</p> <p>Witnessing someone inject is the most important and useful time to identify, advise and correct poor technique to reduce harm.</p> |
| 26 | Can people out-with the Kings Cross area use MSIC and how far do people travel to use it? | <p>Anyone can use the centre, regardless of where they're from.</p> <p>The MSIC is not what attracts people to the area, it is the Kings Cross area where people go to buy the drugs, which has always been the case even before the MSIC was established. So people may travel in from surrounding areas but have generally been in Kings Cross for the previous 24 hours. People do not buy their drugs from elsewhere then travel in to Kings Cross to use the MSIC.</p> |
| 27 | What are the opening hours? | <p>The MSIC is open 363 days a year (it closes 2 days for all staff training).</p> <p>It operates from 09:30 – 21:30 five days a week, apart from a Tuesday when the service shuts from 15:45 to 18:00 for staff training and meetings.</p> <p>At the weekends it is open from 09:30 – 17:30</p> |

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| 28 | What would the long/short term health benefits be if opened in Scotland? | There is no reason to expect that the positive outcomes would be any different to the outcomes experienced by the MSIC, as stated in Q.16 |
| 29 | Has MSIC helped families? | A lot of people who attend the MSIC have lost touch with their families. Due to confidentiality the centre cannot give family members information who may sometimes call. Feedback from some family members has been positive about the MSIC and certainly some of the main advocates have been family members. |
| 30 | Why have no other centres been opened in Australia? | Politics partly but then the reduction in drug-related deaths has limited the conversation on the subject with it being less prevalent in the media. The MSIC remains hopeful that other centres will be established. |
| 31 | Were people who inject drugs consulted prior to MSIC opening? Were people concerned about confidentiality/privacy? | Yes, and they helped shape the way the centre runs, the hours and location. The service is confidential and people are not required to provide their real names if they do not wish to. |
| 32 | Do staff have good relationships with people who attend MSIC? What are the qualifications of the staff? | The staff have a variety of backgrounds and experience, all of whom understand the needs of people who use drugs and clearly have good interpersonal skills. The service employs 24 full time equivalent staff comprised of Health Education Officers, Nurses, Administrators, Researchers and a Medical Director. |
| 33 | Is there any peer involvement? | There is a relatively newly established consumer group that meets every 3 weeks in the MSIC with a member of staff at a time when the centre is closed. They feed back client comments and make recommendations to improve the service. There is also a comments book that is reviewed regularly. |
| 34 | Is abstinence a goal? Is rehab encouraged? Does using MSIC replace opiate replacement therapy (ORT)? Is there a recovery ethos? | The goals are set by the client. There is no expectation placed on people that they must stop using drugs and the centre works with people to help them achieve their own goals to improve their own wellbeing. |

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| | | By allowing people this choice they are often more likely to accept ORT, it is not an either/or situation. The MSIC keeps people alive so that they have time to consider accessing treatment. People can still inject in the MSIC if they are on ORT also. The 'recovery ethos' is about improving wellbeing. |
| 35 | Are there safeguards in place to prevent litigation? | Because of the amendment to the law the clients and staff are not breaking the law by attending or providing this service. The service also has insurance. |

CLIENT AND STAFF COMMENTS

I took the opportunity to ask people their views on why they attend the MSIC and why they work there. They were provided with a bit of paper headed with 'I come to the MSIC because...' and without prompting, this is what they said:

I COME TO THE MSIC BECAUSE...

"...I value my life and without them I'd probably be dead. I often use just after I've had a bit to drink, which isn't a great combination and so the MSIC gallery is invaluable in that regard."

"...Since the centre has opened, I no longer have to look over my shoulder for police, shopkeepers, passers by etc. wondering if I'm going to be arrested, moved along or jumped upon by fellow users. I enjoy the safety, cleanliness, provision of clean equipment and staff with the proper training in case anyone drops. As far as I know there hasn't been a death since it opened. The other benefits are the chill out area (free tea and coffee) and the introduction to other services such as housing, detoxing, methadone programs etc. Also the surrounding areas are a lot more cleaner, back street doorways etc."

"...for many a reason...one is for my own health and safety in the sport I decide to play. The other is because I realise the difference, I have seen this place change (the Cross) it's all good. Today for instance I hadn't been here for about a week and several staff members expressed their worry and appreciated the fact I was OK. MSIC has my blessing!"

“...safe and clean place, staff prepared for anything *especially the worst to happen. Should have been done a lot of deaths ago!!!!”

“...it’s the best place to go – can use without discrimination, you can relax and it’s legal. It feels like a library.”

“...to be safe and looked after, get advice off the workers, check up, art, cuppa, food, friends, projects, charge my phone. Mainly because they’re here, we need them. They save lives.”

“...it’s safe, clean, not worry about police officers plus not catching Hep C and other diseases. The staff make us feel like they do as much as they can for us like clean equipment, fresh fruit. Most of all they’re here for us, we’re all like family members. But I’d like to see it in all Australia first and other countries plus it will keep Australia nice and clean not seeing dirty needles on the streets, keeping everything behind closed doors.”

“...it is a safe environment to use your drugs and you get to meet some very nice and interesting people.”

“...it’s a safe place to do our thing and away from the easily led kids of our neighbourhood and their good parents, not drawing blood in front of decent families ie. the law abiding public.”

“...it is a clean and safe place to inject. I feel that I can relax and not be judged or in risk of accidental overdose.”

“...it’s a safe environment to have a shot. There are staff with a medical background in case people have an overdose, with the proper equipment just in case. It is a clean and sterile place with sterile equipment given freely so we don’t get diseases from using dirty equipment.

We can have a cuppa in stage 3 when finished. I truly believe that every town and city should have a place like this for users to safely inject, get information about anything they need and get sterile equipment every time. And a place to dispose of used equipment safely. Many thanks to the team at MSIC for their efforts and help.”

I WORK IN THE MSIC BECAUSE...

“...I love working with people who use drugs, to empower them to help them fight stigma and discrimination and to help put PWUD in the drivers seat of their own health outcomes. Being ‘on the coal face’ at MSIC allows me to do this with the most highly marginalised PWUD, and to spread what I have learned through other voluntary governance work.”

“...I love being part of a very unique service that cares for a marginalised group of people. Plus: I have an awesome team that I work with!!”



Above: with some of the incredible MSIC staff

“...this is the most rewarding, dynamic, funniest place to work at...”

“...people matter. All people matter.”

“...I believe in harm minimisation. We are often the front line health service – many clients will see us before any other health service. A great variety of nursing challenges. I love being an advocate for the under-privileged.”

“...it practices what it preaches and I like what it preaches – the values are important. The staff are great to work with. Location!”

CONCLUSIONS AND RECOMMENDATIONS

Drug-Related Deaths in the UK are at an all time high. Strategies to assist in the reduction of morbidity and mortality associated with problematic drug use must be prioritised and implemented without delay to avoid a continued upward trend in accidental and preventable fatalities.

The learning and evidence from Australia has provided recommendations that should be part of a much bigger picture. Whilst this report will focus on 3 key recommendations gathered during my time in Australia, we cannot afford to ignore the evidence from other countries. We need to be using every single measure available to us in order to prevent further avoidable losses.

There is an imperative for ALL working in the field to take full account of their duty of care towards people using drugs problematically at very high risk of harm.

Scottish Drugs Forum has been working on formalising death-prevention strategies to assist Alcohol and Drug Partnerships, the local planning structures in Scotland to plan responses to drugs and alcohol, to strategically address the issues in their localities. The report is currently in draft form and will be published later this year.

The key findings from the report will fall under the following headings:

Low threshold services/retention in services
Assertive outreach/wound care/bacterial infections
Responding to people experiencing non-fatal overdoses
Dual diagnosis and suicide
BBV testing and treatment
Continuity of care
Throughcare
Information sharing and assessments
Specific needs of older drug users
Attitudes and Stigma
Naloxone
Homelessness

These key findings will be accompanied by measures:

Non-fatal overdose; information sharing and assertive outreach
Needs assessment for vulnerable populations
Risk assessment/risk management/low threshold services
Active case finding and treatment for HCV and other injecting-related infections
Active retention in services
Greater engagement with GP services
Greater engagement with Pharmacy
Information sharing
New psychoactive substances
Provision of naloxone
Suicide awareness/prevention
Communication/information/education/training

Recommendation One: SUPERVISED INJECTING FACILITIES

Wherever there are significant numbers of people injecting in public, there is a clear need for supervised injecting facilities.

Actions required:

- Scottish Government to request guidance from the Crown Office and the Lord Advocate to allow the legal operation of SIFs. This may initially be for one pilot site but legal guidance should not be restrictive and allow for multiple sites in the future. Ultimately there should be legislative changes to the Misuse of Drugs Act in the UK.
- Local areas to conduct a needs assessment in relation to the prevalence of public injecting.
- Scottish Government to provide funding for a pilot site, which would also be an evaluation project, to inform future sites. The potential for utilisation of the confiscated proceeds of crime funds, as in Australia, should be explored.
- Combining the international evidence of SIFs and treatment, sites should seek to provide many different services in addition to an injecting room - such as an inhalation facility and low threshold ORT. Consideration should also be given to the availability of heroin-assisted treatment within sites.

Recommendation Two: TAKE-HOME NALOXONE

Take-Home Naloxone should be available free of charge, and promoted widely, to those most likely to witness an overdose.

The World Health Organisation also recommended this:

‘People likely to witness an opioid overdose should have access to naloxone and be instructed in its administration to enable them to use it for the emergency management of suspected opioid overdose’. (WHO guidelines on the Community Management of Opioid Overdose, 2014)

Worldwide, the WHO estimate 69,000 people die from opioid overdose each year.

Scotland’s National Naloxone Programme was announced late 2010 and commenced early 2011. To date, 21,140 kits have been supplied across the country with 1500+ reported uses, which have successfully reversed an overdose (National Naloxone Programme Scotland – Monitoring Report 2014/15, Information Services Division). This is a fantastic achievement but we cannot afford to be complacent.

The aim of any naloxone programme should be to ensure coverage. The more naloxone that is provided, the more likely it is that it will be present when an overdose occurs.

Take-Home Naloxone is an essential component of any drug-death prevention strategy. Recent regulatory changes in the UK allow the wider distribution of THN to extend to anyone working in, or engaged in, drug treatment services.

Actions required:

- Staff, services and peers to be equipped with the necessary skills and knowledge to deliver training on naloxone to people at risk of opiate overdose and others likely to witness an overdose
- The provision of take-home naloxone kits should be prioritised to those most likely to witness an overdose
- Services in contact with people who use drugs should have access to naloxone for use in an emergency
- In line with new regulations, naloxone should also be distributed via 3rd sector organisations and peers

Recommendation Three: ACTIVE ENGAGEMENT AND RETENTION IN TREATMENT

Low threshold services should be widely available across the country.

Opiate replacement therapy is a protective factor against overdose fatality. More needs to be done to ensure that services meet the needs of people who use drugs problematically to promote better engagement and retention.

People should not be discharged from ORT because of perceived non-compliance with the service's expectations. Many people are removed from ORT due to continued (despite reduced) use of illicit drugs and for lack of engagement with the service, including missed appointments.

Waiting time targets introduced in Scotland have successfully reduced the time people wait for assessment with treatment services but they do not go far enough. There is a need for low-threshold services equipped to start people on ORT immediately when they present.

'Low-threshold services for drug users can be defined as those which offer services to drug users; do not impose abstinence from drug use as a condition of service access; and endeavour to reduce other documented barriers to service access'²

Actions required:

- Low threshold services to be introduced in all areas, this does not necessarily mean new services but could also mean the adaptation of current service provision.
- Managers and service providers should evaluate if current service provision is inclusive and meeting the needs of the target population.
- Managers and service providers should ensure that any negative staff attitudes towards the client group are addressed.
- Managers should support staff to actively engage and retain people in treatment rather than discharging people before they are ready.
- Assertive outreach should be introduced as part of low threshold services.

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